



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH OF CLEBURNE
3255 W PIONEER PKWY
ARLINGTON TX 76013

Respondent Name

Zurich American Insurance Co

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-2335-01

MFDR Date Received

March 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please submit this claim for the correct allowable per ASC RULE 134:402: Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

Amount in Dispute: \$68.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier asserts that absent a timely and correctly completed bill for this item reimbursement is not owed."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2011	Outpatient Hospital Services	\$68.99	\$68.99

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 31, 2011

- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS MARKUP.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE

- 619 – THE PROCEDURE/SUPPLY WAS NOT SUFFICIENTLY IDENTIFIED AND/OR QUANTIFIED.
- WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

Explanation of benefits dated January 9, 2012

- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS MARKUP.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE
- 619 – THE PROCEDURE/SUPPLY WAS NOT SUFFICIENTLY IDENTIFIED AND/OR QUANTIFIED.
- WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Per Medicare policy, procedure code 73130 may not be reported with procedure code billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 73130 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$25.83. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$43.85. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$43.85. This amount multiplied by 200% yields a MAR of \$87.70.
 - Procedure code 12002 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0133, which, per OPPS Addendum A, has a payment rate of \$91.81. This amount multiplied by 60% yields an unadjusted labor-related amount of \$55.09. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$52.67. The non-labor related portion is 40% of the APC rate or \$36.72. The sum of the labor and non-labor related amounts is \$89.39. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation.

This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$89.39 divided by the sum of all S and T APC payments of \$215.83 gives an APC payment ratio for this line of 0.414169, multiplied by the sum of all S and T line charges of \$742.00, yields a new charge amount of \$307.31 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$89.39. This amount multiplied by 200% yields a MAR of \$178.78.

- Procedure code 29125 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0058, which, per OPPS Addendum A, has a payment rate of \$77.15. This amount multiplied by 60% yields an unadjusted labor-related amount of \$46.29. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$44.26. The non-labor related portion is 40% of the APC rate or \$30.86. The sum of the labor and non-labor related amounts is \$75.12. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$75.12 divided by the sum of all S and T APC payments of \$215.83 gives an APC payment ratio for this line of 0.348052, multiplied by the sum of all S and T line charges of \$742.00, yields a new charge amount of \$258.25 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$75.12. This amount multiplied by 200% yields a MAR of \$150.24.
- Procedure code 90471 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of \$26.35. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.81. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$15.12. The non-labor related portion is 40% of the APC rate or \$10.54. The sum of the labor and non-labor related amounts is \$25.66. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$25.66 divided by the sum of all S and T APC payments of \$215.83 gives an APC payment ratio for this line of 0.11889, multiplied by the sum of all S and T line charges of \$742.00, yields a new charge amount of \$88.22 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$25.66. This amount multiplied by 200% yields a MAR of \$51.32.
- Procedure code 96372 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of \$26.35. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.81. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$15.12. The non-labor related portion is 40% of the APC rate or \$10.54. The sum of the labor and non-labor related amounts is \$25.66. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$25.66 divided by the sum of all S and T APC payments of \$215.83 gives an APC payment ratio for this line of 0.11889, multiplied by the sum of all S and T line charges of \$742.00, yields a new charge amount of \$88.22 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$25.66. This amount multiplied by 200% yields a MAR of \$51.32.

- Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC ; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$222.58. This amount multiplied by 60% yields an unadjusted labor-related amount of \$133.55. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$127.69. The non-labor related portion is 40% of the APC rate or \$89.03. The sum of the labor and non-labor related amounts is \$216.72. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$216.72. This amount multiplied by 200% yields a MAR of \$433.44.
 - Procedure code J0696 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 90714 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
3. The total allowable reimbursement for the services in dispute is \$952.80. The amount previously paid by the insurance carrier is \$871.53. The requestor is seeking additional reimbursement in the amount of \$68.99. This amount is recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$68.99.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$68.99, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 15, 2013 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.